Understanding Diagnosis Coding in PDGM for Compliance and Optimum Financial Performance
Understanding Diagnosis Coding in PDGM for Compliance and Optimum Financial Performance

The art of life is a constant readjustment to our surroundings. -
-
Kakuzo Okakura
TABLE OF CONTENTS

- Explain the Impact of Coding under PGDM
- Evaluate the specificity requirements of coding under PDGM
- What your agency should be doing now to prepare for coding under PDGM

PDGM – Payment Groupings Overview

- CY 2019 Home Health final rule, PDGM will be implemented for 30-day periods of care starting on or after January 1, 2020
  - PDGM uses 30-day periods as a basis for payment.
  - 30-day periods are categorized into 432 case-mix groups for the purposes of adjusting payment in PDGM.
PDGM - Subgroups

• 30-day periods are placed into different subgroups for each of the following categories:
  
  – Admission source (two subgroups):
    • Community or
    • Institutional admission source
  
  – Timing of the 30-day period (two subgroups):
    • Early (first 30-day period) or
    • Late (every subsequent payment period after the first period)

PDGM - Subgroups

• Clinical Grouping - Twelve groups based on Primary diagnosis:
  – Musculoskeletal Rehabilitation
  – Neuro/Stroke Rehabilitation
  – Wounds
  – Behavioral Health Care
  – Complex Nursing Interventions
  – MMTA - Surgical Aftercare
  – MMTA - Cardiac and Circulatory
  – MMTA - Endocrine
  – MMTA - Gastrointestinal Tract and Genitourinary System
  – MMTA - Infectious Disease, Neoplasms, and Blood-Forming Diseases
  – MMTA - Respiratory
  – MMTA - Other

Note: MMTA = Medication Management, Teaching, Assessment
PDGM - Subgroups

• Functional Impairment Level (three subgroups)

• Low, Medium, or High-based on the OASIS responses to:
  – M1800 - grooming
  – M1810 - upper body dressing
  – M1820 - lower body dressing
  – M1830 - bathing
  – M1840 - toilet transferring
  – M1850 - transferring
  – M1860 - ambulation/locomotion
  – M1033 - hospitalization risk - *excluding responses 8-reports exhaustion, 9-risk(s) not listed in 1-8, and 10-none of the above

PDGM - Subgroups

• Comorbidity Adjustment
  – From Secondary Diagnosis Reported on Claims
    • None
    • Low
    • High
Patient-Driven Groupings Model (PDGM)

PDGM Coding Impacts
Coding Impact on PDGM Groupings Model

- 2 of the 5 categories are based on the diagnoses coding
  - Clinical Grouping
    - From Principal Diagnosis Reported on Claim
  - Comorbidity Adjustment
    - From Secondary Diagnoses Reported on Claim

- Clinical Group Coding
  - Key component of determining payment in PDGM is the 30-day period’s clinical group assignment
    - Based on the principal diagnosis code for the patient as reported by the HHA on the home health claim.

<table>
<thead>
<tr>
<th>CLINICAL GROUP</th>
<th>PRINCIPAL REASON FOR HOME HEALTH ENCOUNTER IS TO PROVIDE:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Musculoskeletal Rehabilitation</td>
<td>Therapy (PT/OT/SLP) for a musculoskeletal condition</td>
</tr>
<tr>
<td>Neuro/Stroke Rehabilitation</td>
<td>Therapy (PT/OT/SLP) for a neurological condition or stroke</td>
</tr>
<tr>
<td>Wounds - Post-Op Wound Aftercare and Skin/ Non-Surgical Wound Care</td>
<td>Assessment, treatment and evaluation of a surgical wound(s); assessment, treatment and evaluation of non-surgical wounds, ulcers burns and other lesions</td>
</tr>
<tr>
<td>Behavioral Health Care</td>
<td>Assessment, treatment and evaluation of psychiatric and substance abuse conditions</td>
</tr>
<tr>
<td>Complex Nursing Interventions</td>
<td>Assessment, treatment and evaluation of complex medical and surgical conditions including IV, TPN, enteral, nutrition, ventilator, and ostomies</td>
</tr>
</tbody>
</table>

**Medication Management, Teaching and Assessment (MMTA)**

- MMTA – Surgical Aftercare: Assessment, evaluation, teaching, and medication management for Surgical Aftercare
- MMTA – Cardiac/Circulatory: Assessment, evaluation, teaching, and medication management for Cardiac or other circulatory related conditions
- MMTA – Endocrine: Assessment, evaluation, teaching, and medication management for Endocrine related conditions
- MMTA – GI/GU: Assessment, evaluation, teaching, and medication management for Gastrointestinal or Genitourinary related condition
- MMTA – Infectious Disease/Neoplasms/ Blood-forming Diseases: Assessment, evaluation, teaching, and medication management for conditions related to Infectious diseases/Neoplasms/ Blood-forming Diseases
- MMTA – Respiratory: Assessment, evaluation, teaching, and medication management for Respiratory related conditions
- MMTA – Other: Assessment, evaluation, teaching, and medication management for a variety of medical and surgical conditions not classified in one of the previously listed groups

Reference: Federal Register/Vol. 84, No. 138/Thursday, July 18, 2019/Proposed Rules
PDGM - Comorbidity Coding

- OASIS only allows HHAs to designate 1 primary diagnosis and 5 secondary diagnoses, however, the home health claim allows HHAs to designate 1 principal diagnosis and 24 secondary diagnoses.

- All 24 secondary diagnoses can impact reimbursement

- The comorbidity adjustment in PDGM can increase payment by up to 20 percent.

---

PDGM - Comorbidity Coding

- 30-day periods of care can receive a comorbidity adjustment under the following circumstances:
  - No comorbidity adjustment:
    - No secondary diagnoses exist, or none meet the criteria for a low or high comorbidity adjustment
  
  - Low comorbidity adjustment:
    - There is a secondary diagnosis on the HH-specific comorbidity subgroup list that is associated with higher resource use.
  
  - High comorbidity adjustment:
    - 2 or more secondary diagnoses on the HH-specific comorbidity subgroup interaction list that are associated with higher resource use when both are reported together compared to if they were reported separately.
      - The two diagnoses may interact with one another, resulting in higher resource use.
PDGM - Comorbidity Adjustment

• Only one comorbidity adjustment is permitted
  – A 30-day period of care can receive only one low comorbidity adjustment or one high comorbidity adjustment
    • Regardless of the number of secondary diagnoses or high comorbidity subgroup interactions reported on the claim
  – The highest level will be assigned

• 12 comorbidity subgroups receive the low comorbidity adjustment
• 34 comorbidity subgroup interactions receive the high comorbidity adjustment, as noted in the tables on the following slides
### PDGM - Low Comorbidity Adjustment Subgroups

**TABLE 10: LOW COMORBIDITY ADJUSTMENT SUBGROUPS FOR CY 2020**

<table>
<thead>
<tr>
<th>Comorbidity Subgroup</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cerebral 4</td>
<td>Includes sequelae of cerebral vascular diseases</td>
</tr>
<tr>
<td>Circulatory 10</td>
<td>Includes varicose veins with ulceration</td>
</tr>
<tr>
<td>Circulatory 9</td>
<td>Includes acute and chronic embolisms and thrombosis</td>
</tr>
<tr>
<td>Heart 10</td>
<td>Includes cardiac dysrhythmias</td>
</tr>
<tr>
<td>Heart 11</td>
<td>Includes heart failure</td>
</tr>
<tr>
<td>Neoplasms 1</td>
<td>Includes oral cancers</td>
</tr>
<tr>
<td>Neuro 10</td>
<td>Includes peripheral and polyneuropathies</td>
</tr>
<tr>
<td>Neuro 5</td>
<td>Includes Parkinson’s disease</td>
</tr>
<tr>
<td>Skin 1</td>
<td>Includes cutaneous abscess, cellulitis, lymphangitis</td>
</tr>
<tr>
<td>Skin 3</td>
<td>Includes diseases of arteries, arterioles, and capillaries with ulceration and non-pressure, chronic ulcers</td>
</tr>
<tr>
<td>Skin 4</td>
<td>Includes Stages Two through Four and Unstageable pressure ulcers</td>
</tr>
</tbody>
</table>

*Source: CY 2018 Medicare claims data for episodes ending on or before December 31, 2018.*

Reference: Federal Register/Vol. 84, No. 138/Thursday, July 18, 2019/Proposed Rules

---

### PDGM - High Comorbidity Adjustment Interaction Subgroups

**TABLE 11: HIGH COMORBIDITY ADJUSTMENT INTERACTION SUBGROUPS FOR CY 2020**

<table>
<thead>
<tr>
<th>Comorbidity Subgroup Interaction</th>
<th>Comorbidity Subgroup</th>
<th>Description</th>
<th>Comorbidity Subgroup</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Behavioral 2</td>
<td>Includes depression and bipolar disorder</td>
<td>Skin 3</td>
<td>Includes diseases of arteries, arterioles, and capillaries with ulceration and non-pressure, chronic ulcers</td>
</tr>
<tr>
<td>2</td>
<td>Cerebral 4</td>
<td>Includes sequelae of cerebral vascular diseases</td>
<td>Circulatory 4</td>
<td>Includes hypertensive chronic kidney disease</td>
</tr>
<tr>
<td>3</td>
<td>Cerebral 4</td>
<td>Includes sequelae of cerebral vascular diseases</td>
<td>Heart 11</td>
<td>Includes heart failure</td>
</tr>
<tr>
<td>4</td>
<td>Cerebral 4</td>
<td>Includes sequelae of cerebral vascular diseases</td>
<td>Neuro 10</td>
<td>Includes peripheral and polyneuropathies</td>
</tr>
<tr>
<td>5</td>
<td>Circulatory 4</td>
<td>Includes hypertensive chronic kidney disease</td>
<td>Skin 1</td>
<td>Includes cutaneous abscess, cellulitis, lymphangitis</td>
</tr>
<tr>
<td>6</td>
<td>Circulatory 4</td>
<td>Includes hypertensive chronic kidney disease</td>
<td>Skin 3</td>
<td>Includes diseases of arteries, arterioles, and capillaries with ulceration and non-pressure, chronic ulcers</td>
</tr>
<tr>
<td>7</td>
<td>Circulatory 4</td>
<td>Includes hypertensive chronic kidney disease</td>
<td>Skin 4</td>
<td>Includes Stages Two Through Four and Unstageable Pressure ulcers</td>
</tr>
<tr>
<td>8</td>
<td>Circulatory 7</td>
<td>Includes atherosclerosis</td>
<td>Skin 3</td>
<td>Includes diseases of arteries, arterioles, and capillaries with ulceration and non-pressure, chronic ulcers</td>
</tr>
<tr>
<td>9</td>
<td>Endocrine 3</td>
<td>Includes diabetes with complications</td>
<td>Neuro 5</td>
<td>Includes Parkinson’s disease</td>
</tr>
<tr>
<td>10</td>
<td>Endocrine 3</td>
<td>Includes diabetes with complications</td>
<td>Neuro 7</td>
<td>Includes hemiplegia, paraplegia, and quadriplegia</td>
</tr>
<tr>
<td>11</td>
<td>Endocrine 3</td>
<td>Includes diabetes with complications</td>
<td>Skin 1</td>
<td>Includes cutaneous abscess, cellulitis, lymphangitis</td>
</tr>
<tr>
<td>12</td>
<td>Endocrine 3</td>
<td>Includes diabetes with complications</td>
<td>Skin 3</td>
<td>Includes diseases of arteries, arterioles, and capillaries with ulceration and non-pressure, chronic ulcers</td>
</tr>
</tbody>
</table>

Reference: Federal Register/Vol. 84, No. 116/Thursday, July 18, 2019/Proposed Rules
## PDGM - High Comorbidity Adjustment Interaction Subgroups

**TABLE 11: HIGH COMORBIDITY ADJUSTMENT INTERACTION SUBGROUPS FOR CY 2020**

<table>
<thead>
<tr>
<th>Comorbidity Subgroup Interaction</th>
<th>Comorbidity Subgroup</th>
<th>Description</th>
<th>Comorbidity Subgroup</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>13</td>
<td>Heart 10</td>
<td>Includes cardiac dysrhythmias</td>
<td>Skin 3</td>
<td>Includes diseases of arteries, arterioles, and capillaries with ulceration and non-pressure, chronic ulcers</td>
</tr>
<tr>
<td>14</td>
<td>Heart 10</td>
<td>Includes cardiac dysrhythmias</td>
<td>Skin 4</td>
<td>Includes Stages Two Through Four and Unstageable Pressure ulcers</td>
</tr>
<tr>
<td>15</td>
<td>Heart 11</td>
<td>Includes heart failure</td>
<td>Neuro 10</td>
<td>Includes peripheral and polyneuropathies</td>
</tr>
<tr>
<td>16</td>
<td>Heart 11</td>
<td>Includes heart failure</td>
<td>Neuro 5</td>
<td>Includes Parkinson's disease</td>
</tr>
<tr>
<td>17</td>
<td>Heart 11</td>
<td>Includes heart failure</td>
<td>Skin 1</td>
<td>Includes cutaneous abscess, cellulitis, lymphangitis</td>
</tr>
<tr>
<td>18</td>
<td>Heart 11</td>
<td>Includes heart failure</td>
<td>Skin 3</td>
<td>Includes diseases of arteries, arterioles, and capillaries with ulceration and non-pressure, chronic ulcers</td>
</tr>
<tr>
<td>19</td>
<td>Heart 11</td>
<td>Includes heart failure</td>
<td>Skin 4</td>
<td>Includes Stages Two Through Four and Unstageable Pressure ulcers</td>
</tr>
<tr>
<td>20</td>
<td>Heart 12</td>
<td>Includes other heart diseases</td>
<td>Skin 3</td>
<td>Includes diseases of arteries, arterioles, and capillaries with ulceration and non-pressure, chronic ulcers</td>
</tr>
<tr>
<td>21</td>
<td>Heart 12</td>
<td>Includes other heart diseases</td>
<td>Skin 4</td>
<td>Includes Stages Two Through Four and Unstageable Pressure ulcers</td>
</tr>
</tbody>
</table>

Reference: Federal Register/Vol. 84, No. 138/Thursday, July 18, 2019/Proposed Rules
# PDGM - High Comorbidity Adjustment Interaction Subgroups

<table>
<thead>
<tr>
<th>Comorbidity Subgroup Interaction</th>
<th>Comorbidity Subgroup</th>
<th>Description</th>
<th>Comorbidity Subgroup</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>28</td>
<td>Renal 1</td>
<td>Includes chronic kidney disease and ESRD</td>
<td>Skin 3</td>
<td>Includes diseases of arteries, arterioles, and capillaries with ulceration and non-pressure, chronic ulcers</td>
</tr>
<tr>
<td>29</td>
<td>Renal 1</td>
<td>Includes chronic kidney disease and ESRD</td>
<td>Skin 4</td>
<td>Includes Stages Two Through Four and Unstageable Pressure ulcers</td>
</tr>
<tr>
<td>30</td>
<td>Renal 3</td>
<td>Includes nephrogenic diabetes insipidus</td>
<td>Skin 4</td>
<td>Includes Stages Two Through Four and Unstageable Pressure ulcers</td>
</tr>
<tr>
<td>31</td>
<td>Resp 5</td>
<td>Includes COPD and asthma</td>
<td>Skin 3</td>
<td>Includes diseases of arteries, arterioles, and capillaries with ulceration and non-pressure, chronic ulcers</td>
</tr>
<tr>
<td>32</td>
<td>Resp 5</td>
<td>Includes COPD and asthma</td>
<td>Skin 4</td>
<td>Includes Stages Two Through Four and Unstageable Pressure ulcers</td>
</tr>
<tr>
<td>33</td>
<td>Skin 1</td>
<td>Includes cutaneous abscess, cellulitis, lymphangitis</td>
<td>Skin 3</td>
<td>Includes diseases of arteries, arterioles, and capillaries with ulceration and non-pressure, chronic ulcers</td>
</tr>
<tr>
<td>34</td>
<td>Skin 3</td>
<td>Includes diseases of arteries, arterioles, and capillaries with ulceration and non-pressure, chronic ulcers</td>
<td>Skin 4</td>
<td>Includes Stages Two Through Four and Unstageable Pressure ulcers</td>
</tr>
</tbody>
</table>

Reference: Federal Register/Vol. 84, No. 138/Thursday, July 18, 2019/Proposed Rules

---

## PDGM - Comorbidity Adjustment Example

- **Low comorbidity adjustment**

- **Example**
  - Secondary diagnosis of I50.9 Heart failure, unspecified
  - No additional comorbid diagnoses on the claim that fall into a Low or High Comorbidity Subgroup
  - I50.9 falls into Low Comorbidity Subgroup - Heart 11
PDGM - Comorbidity Adjustment Example

• High comorbidity adjustment

• Example
  – I50.32 Chronic diastolic (congestive) heart failure-Comorbidity Group Heart 11 and G20 Parkinson's disease- Comorbidity Group Neuro 5
    • Both of these diagnoses when reported on the same claim fall within one of the 34 high comorbidity adjustment interaction subgroups

Low Comorbidity – Coding Scenario

• Referral from the hospital for Mr. Smith after he was admitted for a wound to his right calf
• Per the physician documentation, the patient has stasis dermatitis and developed a stasis ulcer to the right calf that currently has the fat layer exposed.
• The patient also has a diagnosis of hypertension
• The referral is for wound care twice a week.

Question
  – How would you code the Primary and Secondary Diagnoses based on the above scenario?
Low Comorbidity – Coding Scenario – Answer

• Primary Diagnosis:
  – I87.2 Venous insufficiency (chronic) (peripheral) - MMTA-CARDIAC
    • This diagnosis is primary per coding guidelines- the associated underlying condition is coded first followed by the appropriate L97 code

• Secondary Diagnoses:
  – L97.212 Non-pressure chronic ulcer of right calf with fat layer exposed – Comorbidity Subgroup Skin 3
  – I10 Essential (primary) hypertension – No Comorbidity Subgroup

• Low Comorbidity Adjustment - there is a reported secondary diagnosis, L97.212, that falls within one of the HH specific individual comorbidity subgroups - Skin 3

Low Comorbidity – Coding Scenario
First 30-Day Period

• First 30-day period

• Scenario based on:
  – Admission Source – Institutional
  – Timing – Early
  – Clinical Group – MMTA-CARDIAC
  – Functional Impairment Level – Low
  – Comorbidity Adjustment - Low

• HIPPS of 2HA21, Case Mix weight of 1.2138, LUPA threshold of 4, Payment $2,536
**Low Comorbidity – Coding Scenario**

**Second 30-Day Period**

- Second 30-day period with no changes in diagnoses

- Scenario based on:
  - Admission Source – Community
  - Timing – Late
  - Clinical Group – MMTA-CARDIAC
  - Functional Impairment Level – Low
  - Comorbidity Adjustment - Low

- HIPPS of 3HA21, Case Mix Weight of 0.6277, LUPA threshold of 2, Payment - $1,311

---

**High Comorbidity - Coding Scenario**

- Mrs. Adams was discharged from the hospital, where she was newly diagnosed with acute exacerbation of diastolic CHF. While hospitalized, she was noted to have a Stage 2 pressure ulcer to her coccyx.
- She has history of hypertension.
- Physician referred to home health to monitor cardiac status and BP, teach disease process CHF, and wound care to pressure ulcer

**Question**

- How would you code the Primary and Secondary Diagnoses based on the above scenario?
High Comorbidity Coding Scenario - Answer

- Primary Diagnosis:
  - I11.0 Hypertensive heart disease with heart failure – Clinical Group MMTA-CARDIAC

- Secondary Diagnoses:
  - I50.31 Acute diastolic (congestive) heart failure - Comorbidity Subgroup Heart 11
  - L89.152 Pressure ulcer of sacral region, stage 2 - Comorbidity Subgroup Skin 4

- High Comorbidity adjustment - there 2 or more secondary diagnoses that fall within one or more of the comorbidity interaction subgroups – subgroup 19 - Heart 11/Skin 4

High Comorbidity – Coding Scenario
First 30-Day Period

- First 30-day period

- Scenario based on:
  - Admission Source – Institutional
  - Timing – Early
  - Clinical Group – MMTA-CARDIAC
  - Functional Impairment Level – Low
  - Comorbidity Adjustment – High

- HIPPS of 2HA31, case mix weight of 1.3389, LUPA threshold of 4, and payment of $2,797
High Comorbidity – Coding Scenario
Second 30-Day Period

• Second 30-day period with no diagnoses changes

• Scenario based on:
  – Admission Source – Community
  – Timing – Late
  – Clinical Group – MMTA-CARDIAC
  – Functional Impairment Level – Low
  – Comorbidity Adjustment – High

• HIPPS of 3HA31, case mix weight of 0.7528, LUPA threshold of 3, and payment of $1,573

High Comorbidity - Coding Scenario

• Mr. Jones is seen in physician office after being discharged from the hospital 2 days ago, where he was treated for exacerbation of COPD and elevated BP.
• He continues to take decreasing doses of prednisone. BP elevated at physician appointment and physician increased dose of Lisinopril.
• Patient complained of pain on his bottom when sitting- found to have Stage 2 pressure ulcer of the coccyx.
• He has history of CHF, Atrial Fib, Parkinson’s Disease, & he is taking Coumadin.
• Physician referred to HH- wound care to pressure ulcer 3x/week, monitor resp status, monitor BP, response to med change & ordered PT/INR.

Question
  – How would you code the Primary and Secondary Diagnoses based on the above scenario?
High Comorbidity Coding Scenario - Answer

- **Primary Diagnosis:**
  - L89.152 Pressure ulcer of sacral region, stage 2 - Clinical Group WOUND
    - This diagnosis is primary as it requires the most intensive skilled service

- **Secondary Diagnoses:**
  - J44.1 Chronic obstructive pulmonary disease with (acute) exacerbation - Comorbidity Subgroup Resp 5
  - I11.0 Hypertensive heart disease with heart failure - Comorbidity Subgroup Heart 11
  - I50.9 Heart failure, unspecified - Comorbidity Subgroup Heart 11
  - I48.91 Unspecified atrial fibrillation - Comorbidity Subgroup Heart 10
  - G20 Parkinson’s Disease - Comorbidity Subgroup Neuro 5
  - Z51.81 Encounter for therapeutic drug level monitoring - Not in Clinical Grouping
  - Z79.01 Long term (current) use of anticoagulants - Not in Clinical Grouping

High Comorbidity – Coding Scenario

- This scenario would receive a High Comorbidity adjustment - there 2 or more secondary diagnoses that fall within one or more of the comorbidity interaction subgroups – subgroup 16 - Heart 11/Neuro 5
  - As you can see, it is important to list all diagnoses that affect the plan of care
High Comorbidity – Coding Scenario
First 30-Day Period

• First 30-day period

• Scenario based on:
  – Admission Source – Institutional
  – Timing – Early
  – Clinical Group – Wound
  – Functional Impairment Level – Low
  – Comorbidity Adjustment – High

• HIPPS of 2CA31, case mix weight of 1.5865, LUPA threshold of 4, and payment of $3,314

High Comorbidity – Coding Scenario
Second 30-Day Period

• Second 30-day period with no diagnoses changes

• This scenario based on:
  – Admission Source – Community
  – Timing – Late
  – Clinical Group – Wound
  – Functional Impairment Level – Low
  – Comorbidity Adjustment – High

• HIPPS of 3CA31, case mix weight of 1.0005, LUPA threshold of 3, and payment of $2,090
**PDGM – Comorbidity Coding**

- ICD – 10 Coding Guidelines require reporting of all secondary (additional) diagnoses that affect the plan of care

- New Language "Secondary diagnoses are only to be reported if they are conditions that affect patient in terms of requiring clinical evaluation; therapeutic treatment; diagnostic procedures; extended length of hospital stay; or increased nursing care and/or monitoring"
  - Previous language "potentially affect the patient's care"

- New Language "We do not expect that HHAs would report comorbid conditions that are not being addressed in the individualized plan of care"

**PDGM – Comorbidity Coding- Sequencing**

- Place diagnoses in order to best reflect the seriousness of the patient's condition and to justify the disciplines and services in accordance with the ICD -10 Coding Guidelines

- Be sure to Sequence of codes following ICD guidelines for reporting: Manifestation codes, 'Code First', Excludes 1 Notes

- Medicare does not have any additional requirements regarding the reporting or sequence of the codes beyond those contained in ICD guidelines.

Reference: CMS Transmittal 4312, dated, May 23, 2019
PDGM – Comorbidity Coding

- Case-mix variables in PDGM work in tandem to
  - Account for the complexity of patient care needs
  - Make payment for home health services accordingly

- Follow Coding Guidelines and code to what the physician documents and the OASIS assessment indicates is appropriate!
PDGM - "Unaccepted Diagnosis"

- Based on the primary diagnosis, each 30-day period will be placed into one of the 12 clinical groupings
- If the primary diagnosis does not fit into one of the 12 clinical groups in the payment model, this is considered an "Unaccepted Diagnosis"
- These were formerly called, “Questionable Encounters”
  - Keep in mind that "UD" or “QE” means a patient’s diagnosis isn’t appropriate for a Medicare Home Health encounter!

PDGM - "Unaccepted Diagnosis"

- Submission of an "Unaccepted Diagnosis"
  - If a claim is submitted with a primary diagnosis that doesn’t fit into one of the 12 clinical groupings, the claim will be sent back to the agency as an “RTP”- Return to Provider.
  - The agency will then need to review & resubmit the claim with a more appropriate primary diagnosis which does fit into a clinical grouping.
PDGM - "Unaccepted Diagnosis"

- Complete list of ICD–10–CM codes and their assigned clinical groupings is found on the CMS HHA Center web page - https://www.cms.gov/center/provider-type/home-health-agency-hha-center.html
  - Become familiar with codes that would be used to group 30-day periods of care into the 12 clinical groupings
  - Number of returned claims should be minimal
    - Avoid listing codes as the principal diagnosis code on the claim that are known "unaccepted diagnosis"
    - Diagnoses that will not be allowed as a primary diagnosis for Medicare under PDGM may be allowed as primary diagnoses for other insurances.

5 Star Consultants
Unaccepted Diagnosis Top 10 Codes

- M62.81 Muscle Weakness (Generalized)
- M54.5 Low back pain
- R26.81 Unsteadiness on Feet
- R26.89 Other abnormalities of gait and mobility
- R53.1 Weakness
- G62.9 Polyneuropathy, unspecified
- R29.6 Repeated falls
- R13.10 Dysphagia, unspecified
- R42 Dizziness and giddiness
- M19.90 Unspecified osteoarthritis, unspecified site

Codes in RED are codes are also in the top unaccepted codes found industry wide.
Commonly Used Unaccepted Diagnosis Codes

- L03.90 Cellulitis, unspecified
- L89.--9 Pressure ulcer with unspecified stage
- L98.9 Disorder of the skin and subcutaneous tissue, unspecified
- M06.9 Rheumatoid arthritis, unspecified
  - Alternative code-M06.89-Other specified rheumatoid arthritis, multiple sites
- M25.551 Pain in right hip
- M25.552 Pain in left hip
- M25.651 Pain in right knee
- M25.652 Pain in left knee

Commonly Used Unaccepted Diagnosis Codes

- M48.00 Spinal stenosis, site unspecified
- M54.30 Sciatica, unspecified side
- M62.50 Muscle wasting and atrophy, not elsewhere classified, unspecified site
  - Code for muscle wasting must include site to be accepted as a primary diagnosis
- R26.0 Ataxic gait
- R27.8 Other lack of coordination
- R33.9 Retention of urine, unspecified
- R55 Syncope and collapse
- R25.9 Unspecified convulsions
- S06.9X9D Unspecified intracranial injury with loss of consciousness of unspecified duration
- Z48.89 Encounter for other specified surgical aftercare
- Z51.81 Encounter for therapeutic drug level monitoring
- Z51.89 Encounter for other specified aftercare
- Z91.81 History of falling
Commonly Used Unaccepted Diagnosis Codes

- Many codes that end with the character "9" are unaccepted diagnosis codes as these codes indicate unspecified sites, or unspecified diseases.

- **Remember** - Unacceptable Diagnoses Can be Secondary Diagnoses!

Resolving an Unaccepted Diagnosis Code

- Review documentation thoroughly to see if specific disease information is included.

- Query the physician for:
  - Specific disease information
  - Underlying cause of a symptom
    - Condition causing, for example, Muscle Weakness

- The clinician can determine the site of an issue, such as a wound, and verify/confirm the information with the physician.

- Communication, Communication, Communication!
Coding Specificity:

• Most specific code that describes a medical disease, condition, or injury should be selected.

• “Unspecified” codes are used when there is lack of information about location or severity of medical conditions in the medical record.

• BUT……you are to use a precise code whenever more specific codes are available.

• If additional information regarding the diagnosis is needed, follow-up with the referring provider in order to ensure the Plan of Care (POC) is sufficient in meeting the needs of the patient.
Coding Specificity:

• Many of the codes that indicate pain or contractures as the primary diagnosis, ex: M54.5, Low back pain or M62.422, Contracture of muscle, right hand, is site specific, but doesn’t indicate the cause of the pain or contracture.

• CMS expects a more definitive diagnosis indicating the cause of the pain or contracture, as the reason for the skilled care, in order to appropriately group the home health period.

CMS - Coding Specificity: Muscle Weakness

• M62.81, “Muscle weakness, generalized” is extremely vague, therefore, will not be accepted as a Primary Diagnosis under PDGM
  – “Generalized muscle weakness, while obviously a common condition among recently hospitalized patients, does not clearly support a rationale for skilled services and does not lend itself to a comprehensive plan of care.”
CMS - Coding Specificity: Muscle Weakness

- 2008 HH PPS final rule, CMS- “Muscle Weakness (generalized)” is a nonspecific condition that represents general symptomatic complaints in the elderly population.

- CMS stated that inclusion of this code “would threaten to move the case-mix model away from a foundation of reliable and meaningful diagnosis codes that are appropriate for home care” (72 FR 49774).

Coding Specificity: Use of R Codes

- R codes- that describe signs and symptoms, as opposed to diagnoses- are Unacceptable Diagnoses as principal diagnosis codes

- Use of symptoms, signs, abnormal clinical & lab findings make it difficult to meet the requirements of an individualized plan of care (CoPs).

- Clinically, it is important for HH clinicians to have a clearer understanding of the patients’ diagnoses in order to safely and effectively furnish home health services.
Coding Specificity: Use of R Codes

• Coding guidelines- R codes are to be used when no more specific diagnosis can be made.

• By the time the patient is referred to home health and meets the qualifications of eligibility, a more definitive code should exist to substantiate the need for services.

• This may involve calling the referring physician to gather more information.

Coding Specificity: Use of S and T Codes

• There are many S and T codes where the fracture and/or injury is unspecified, but the site is specified.

• The site of injury and/or fracture should be identified

• The treatment or intervention would likely not change based on the exact type of injury or fracture.

• Many of these codes are appropriate to group into a clinical group, and are either in the musculoskeletal group or the wounds group.
Coding Specificity: Sepsis

- A sepsis diagnosis should be assigned the appropriate code for the underlying systemic infection.
  - These codes will be classified under MMTA—Infectious Disease/Neoplasms/Blood-forming Diseases

NOTE:
- In a case where the patient is receiving an IV antibiotic for sepsis, the HHA is required to code sepsis as the primary diagnosis:
  - The Z code must be listed as the first secondary diagnosis code listed on the claim in order to group the period into the Complex Nursing Interventions group

Coding Specificity: Use of Z Codes

- Z codes may be used as primary diagnosis
  - Z45.2 Encounter for adjustment and management of VAD - COMPLEX Nursing Interventions
  - Z46.6 Encounter for fitting and adjustment of urinary device will be grouped into the - COMPLEX Nursing Interventions
  - Z47.1 Aftercare following joint replacement surgery – MS_REHAB
  - Z48.00 Encounter for change or removal of nonsurgical wound dressings – WOUND
  - Z48.812 Encounter for surgical aftercare following surgery on the circulatory system – MMTA_AFTER

- In addition to the Z codes listed, there are several others- Check in ICD 10 diagnosis list
PDGM
Primary Diagnosis Coding Changes

• If the primary diagnosis changes between the 1st & 2nd 30-day periods, then the claim for the 2nd 30-day period would reflect the new diagnosis
  – Code would not change the claim for the first 30-day period

• Case mix group cannot be adjusted within each 30-day period

• For claim "From" dates on or after January 1, 2020, the ICD-10 code & principle diagnosis used for payment grouping will be from the claim coding rather than the OASIS item.

• The claim and OASIS diagnosis codes will no longer be expected to match in all cases.
PDGM – Primary Diagnosis Changes

• Typically, the codes will match between the 1st claim in an admission & the start of care (Reason for Assessment –RFA 01) assessment & claims corresponding to recertification (RFA 04) assessments.

• 2nd 30-day claims in any 60-day period will not necessarily match the OASIS assessment.

NOTE: When diagnosis codes change between one 30-day claim and the next, a change in the diagnoses does not necessarily mean that an “other follow-up” OASIS assessment (RFA 05) would need to be completed just to make the diagnoses match.

PDGM – SCIC & Other Follow UP OASIS

• HHA is required to complete an ‘other follow-up’ (RFA 05) assessment when such a change would be considered a major decline or improvement in the patient’s health status.

• If a patient experienced a significant change in condition before the start of a subsequent, contiguous 30-day period, for example due to a fall, in accordance with 484.55(d)(1)(ii), the HHA is required to update the comprehensive assessment.
What Should Your Agency Be Doing Now To Prepare For Coding Under PDGM

- It is important to implement changes now and not wait until January 1, 2020

- Revise current coding practices
  - Change coding practices now to assure that primary diagnosis codes being used are approved for use as a primary diagnosis under PDGM.
  - All coders should be educated in the list of diagnosis codes in the PDGM Grouper Tool
  - A complete list of ICD–10–CM codes and their assigned clinical groupings is available on the CMS Home Health Agency (HHA) Center web page: https://www.cms.gov/center/provider-type/home-health-agency-hha-center.html
What Should Your Agency Be Doing Now To Prepare For Coding Under PDGM

• Education for Staff/ Physicians/ Referral sources
  – PDGM coding requirements
    • Specificity needed
      – Codes that may result in an "Unaccepted Diagnosis"
        » R Codes/symptom codes
        » Muscle Weakness/Weakness
        » Falls
        » Difficulty Ambulating/Balance Issues
        » "Unspecified" codes
      • Physician follow up for additional diagnoses information if needed

What Should Your Agency Be Doing Now To Prepare For Coding Under PDGM

• Consider developing a standardized "request for additional diagnosis information " form for use when additional diagnosis information is needed from the physician
  – The form would include an explanation that due to Medicare coding guidelines, additional documentation for the primary diagnosis is needed
    • Primary Diagnosis
    • Symptom code
    • Specific location
    • Wound etiology
      – Etc.
What Should Your Agency Be Doing Now To Prepare For Coding Under PDGM

• EMR
  – Diagnosis coding- will the software allow for secondary diagnosis selection, beyond the five allowable on the OASIS assessment?
  – Functional Impairment Level-OASIS-check for inconsistencies?
  – Admission source and timing?
  – Will the software estimate HHRG placement and communicate the related LUPA visit threshold?
  – Order Tracking?
  – Billing and Claims Management?

What Should Your Agency Be Doing Now To Prepare For Coding Under PDGM

• Coding / OASIS Review

• Consider having coding certified/experienced RN’s reviewing the physician information, OASIS Comprehensive Assessment, and Plan of Care

• Experts to identify Primary Diagnosis that is approved and most accurate for the Patient

• Communicate to assessing clinician and/or Clinical Manager proactively to query physician for more specific diagnoses

• Ensure consistencies between OASIS, Plan of Care and physician information including Face to Face
Intake Tips
Referral Checklist

ACT

Accuracy – important to have accurate and complete referral information

Communication is KEY – communicate with your Intake / referral sources

Train – Train and educate your staff regarding the requirements under PDGM

© 2019 Star Consultants, LLC
Intake Tips

Important:

• Referral Source – where the referral came from

• Admission Source – institutional or community. NEW PDGM
  – Institutional source - has a 14-day admission lookback (acute care and post-acute care)
  – Community source – no 14-day prior admission

• Timing - NEW PDGM
  – First 30-day period – EARLY
  – All subsequent 30-day periods - LATE

Intake Tips - continued

• Diagnosis Coding
  – Gather as much specific documentation as you can at intake.
  – Unspecified codes – unaccepted primary code*
  – Symptom codes – unaccepted primary code*

• Unaccepted ICD 10 codes (previously called questionable encounter codes) – codes that are not grouped for home health reimbursement – cannot be used as a primary diagnosis.
**Intake Referral Checklist Form**

- **Admission Source**
  - Admission Source – Community / Institutional (acute care, post-acute care or inpatient psychiatric hospital in the past 14-days.).
  - Has patient received home health services from any agency in the last 30-days
  - Has the patient been discharged from a post-acute (SNF/rehab) in the last 30-days
  - Admission 14-day lookback (referral source documentation / Medicare Common working file) for all referrals

- **Episode Timing (use Medicare common working file if needed)**

- **Documentation**
  - Face to Face Encounter documentation
  - Detailed documentation supporting medical necessity/need for home health services/homebound status

**Intake Referral Checklist Form - continued**

- **Diagnosis**
  - Gather as much specific documentation as you can at intake.
  - Detailed diagnosis-specific documentation
    - Symptom Codes – need to query physician and/or referral source
    - Unspecified Codes - need to query physician and/or referral source
  - Be knowledgeable of unaccepted ICD 10 codes
  - May need to contact MD for additional documentation for diagnosis

- **Reports**
  - H&P
  - Acute and Post-Acute discharge summary reports
  - Any other reports
Conclusion

• Implement coding training now
  – Have certified, experienced coders!
• Identify the unaccepted diagnoses you have currently and the root cause behind them
• Educate referral sources and physicians
  – Need Specifics!
• Review your agency processes from intake to discharge to identify any changes needed in workflow
• Preparation is vital to having a smooth transition into PDGM beginning January 1, 2020!